



14785 Preston Road, Suite 550 | Dallas, Texas 75254  
Phone: 214 732 9359 | Fax: 972 980 7836

**DATE OF REVIEW: 5/27/2015**

**IRO CASE #**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Permanent Spinal cord Stimulant Implant, Lumbar Spine.

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION**

M.D. Board Certified in Orthopedic Surgery Fellowship Trained Spine Surgeon.

**REVIEW OUTCOME**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)  
 Overturned (Disagree)  
 Partially Overturned (Agree in part/Disagree in part)

**PATIENT CLINICAL HISTORY [SUMMARY]:**

Request is for Spinal Cord Stimulation implantation in a patient who has a chief complaint of chronic low back and leg pain. The patient has had multiple lumbar fusions and decompressions with continued symptoms. The patient is currently being treated with pain management with opioids and neuroleptics. Last year the patient underwent a trial implantation with clinical relief of pain of 75%. Due to significant pain relief, request is made for permanent placement. In addition, the patient underwent psychological testing to assess for confounding variables. These variables have been brought to bear for denial by two previous evaluators. Specifically the psychosocial test revealed an extreme level of perceived disability, extreme peak pain, somatization, compensation focus and history of chemical dependence.

**ANALYSIS FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION AND EXPLANATION OF THE DECISION. INCLUDE CLINICAL BASIS.**

Per ODG references the requested "Permanent Spinal cord Stimulant Implant, Lumbar Spine" is not medically necessary. The patient's history including MRI, psychosocial profile, and previous evaluators' comments, do not support "Permanent Spinal cord Stimulant Implant, Lumbar Spine" at this time because of his failed back syndrome and his psychosocial profile that raise concerns and need better clarification and understanding.



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**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR  
OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TEXAS TACADA GUIDELINES
- TMF SCREENING CRITERIA MANUAL
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES